START-ODS

SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County's Substance Use Disorder Organized Delivery System

Minutes

SYSTEM OF CARE STAKEHOLDER WORKGROUP		
Topic	Recovery Support Services	
Date	July 21, 2016	
Time	9:30 AM – 12:00 PM	
Venue	Conference Room 8050, Building A-8 1000 South Fremont Avenue, Alhambra, CA 91803	
PARTICIPANTS		
Stakeholders	Asian American Drug Abuse Program Behavioral Health Services Behavioral Health Services California Hispanic Commission on Alcohol and Drug Abuse California Pan-Ethnic Health Network CLARE Foundation, Inc. CLARE Foundation, Inc. Didi Hirsch Eldorado Community Service Centers Ettie Lee Homes Fred Brown Recovery Services Helpline Youth Counseling Homeless Healthcare Los Angeles Homeless Healthcare Los Angeles Los Angeles Centers for Alcohol and Drug Abuse Los Angeles Centers for Alcohol and Drug Abuse Los Angeles Centers for Alcohol and Drug Abuse Los Angeles County Department of Child and Family Services Los Angeles Centers for Alcohol and Drug Abuse Medi-Cure Health Services MJB Transitional Recovery Northeast Valley Health Corporation Pacific Clinics People Coordinated Services Phoenix House Phoenix House Prototypes Prototypes Prototypes Safe Refuge SHIELDS for Families Southern California Alcohol and Drug Programs, Inc. Special Services for Groups Special Services for Groups Tarzana Treatment Centers, Inc.	Patty Abrantes Jim Gilmore Denise Shook Denise Orosco Juan Gavidia Diana Cho Jared Friedman Paulla Elmore Donna Palmer Donald Parrington Mark Malone Jihan Mockridge Erika Aguirre-Miyamoto Lori Kizzia Joh Gray Ingrid Soto Bill Tarkanian Stophe Barlock-Page Lucila Vega Jo Kannike-Martins Dennis Hughes Yolanda Cespedes-Knadle David Martel Charlene Scott Erik Sherman Maja Trochimczyk Regina Brown Garett Staley April Wilson Kathy Romo Georgea Madeira Martha Cabrera Heidi De Leon Regina Fair Jose Salazar
SAPC Staff	Yasser Aman, Diana Baumbauer, John Connolly, Loretta Denering, Daniel Deniz, Cecilia Dominguez, Timothy Dueñas, Michelle Gibson, Kristine Glaze, Tina Kim, Yanira Lima, Julie Lo, Elizabeth Norris-Walczak, Ashley Phillips, Glenda Pinney, Steven Reyes, Hyunhye Seo, Valerie Sifuentes, Duy Tran, Gary Tsai, Way Wen, Raymond Low, Wayne Sugita SAPC-Contracted Organization, Health Management Associates: Brooke Ehrenpreis, Meggan Schilkie	

MEETING PROCEEDINGS	
Agenda Items	**Discussion**
I. Welcome and Introduction	John Connolly, SAPC Deputy Director, opened the meeting by welcoming all of the participants and informing them of the proposed recovery support services (RSS) components as drafted by SAPC-contracted field expert, Health Management Associates (HMA). He urged everyone to offer feedback for further improvement of the document, and provided an update about ongoing discussions with the California Department of Health Care Services (DHCS) regarding peer services and related staffing and billing requirements. He further mentioned that there may be a follow-up RSS meeting owing to the volume of information to be covered, and that there is a full narrative accompanying the service components document which will later be sent to the stakeholders.
II. Stakeholder Process Overview	HMA principal staff, Megan Schilkie, facilitated the meeting as assisted by the organization's senior consultant, Brooke Ehrenpreis. Ms. Schilkie served as a former Chief Programs Officer for Mental Health at the New York Department of Health and Mental Hygiene overseeing services like care coordination, crisis services, vocational and rehabilitative programs, housing, and peer support. Ms. Ehrenpreis has facilitated statewide and national efforts on health reform and Medicaid Waiver initiatives. As a way of setting the parameters for the discussion, Ms. Schilkie acknowledged the uniqueness of Los Angeles County's population and context, and stated her plan of sharing RSS best practices as applied nationwide. She also explained her aim of balancing between an overly detailed and widely broad set of guidelines for RSS providers. She described the meeting process beginning with an overview of individual service components, which include goals, modalities, admission/eligibility criteria, limitations/exclusions, staffing levels ratio and experience, and recommendations; and followed by stakeholder feedback.
III. Member Expectations and Ground Rules	Participants were notified to and expected to have reviewed the meeting document in advance, to contribute to the discussion, and to focus on system design and patient care.
IV. Document Review and Discussion	**Workgroup participants reviewed the RSS document and had the recommendations, comments and questions recorded below:** ▪ **<u>Recommendations</u>** - Add telehealth as another mode of delivery for outpatient counseling services. - Establish a uniform term for the RSS plan. RSS is included in the treatment and discharge plan. However, confusion may arise as RSS patients are no longer in substance use disorder (SUD) treatment. Some states and agencies have used "individual service plan" and "recovery plan". "Patient plan" may also be used as a way to promote the mindset that RSS must be patient-driven. - Use consistent staffing terms all throughout the document. For example, "certified recovery coach" was used interchangeably with "peer specialist" under the Recovery Monitoring section. - Refrain from requiring providers to hire new staffing levels and titles. For instance, recovery coaches or peer specialists. - Inform the DHCS-recognized counselor-certifying organizations about RSS peer specialists as they are currently not being offered in their programs. - Clarify how to meet and document medical necessity in RSS.

- Develop a tool that providers can use to assess patients' recovery status, and determine medical necessity at the same time. Tools can be developed according to a peer specialist's skill set. Providers may send any tool that they are currently using to SAPC's Office of the Medical Director and Science Officer (OMDSO) as a reference.
- Organize the information on service components in a matrix to easily compare differences in staffing, modalities and other details across service types.
- Gather information about support group services conducted by other states to open collaboration and sharing of best practices.
- Change the term "support group services" to, for instance, "links to support services". It is a misnomer to call it support group if the services are really individualized. There may be a need to clarify which of the services fall under the category of support, and which are groups.
- Gather input from SAPC's provider network about recommended and reasonable caseloads, and staff-to-patient ratio.

▪ **<u>Comments</u>**

- While RSS benefit is new to Drug Medi-Cal (DMC), SUD providers have been providing recovery services to patients even without billing for them. Now that RSS will be reimbursable under DMC, there needs to be a shift where RSS must strictly be based on recovery goals, and documented in the recovery plan.
- Recommendations under the Substance Abuse Assistance service component are misleading. The populations cited on the RSS list of high-risk groups are largely not in or have gone through SUD treatment for them to be availed of RSS.
- Family Support services need to be offered even before discharge, not just when the patient reaches the recovery phase.
- Per the State, Support Group services are about providing linkages. SAPC still needs to further clarify with the State which particular ones are billable, or if peer specialists can host groups themselves. 12 Step-type programs are not DMC-reimbursable.

▪ **<u>Questions</u>**

- **The outpatient counseling services allows for face-to-face intervention. What about telehealth?**
  - *Telehealth is permissible as stated in the DHCS fact sheet on RSS. Face-to-face encounters via telehealth will be included in future drafts.*
- **Can providers employ registered counselors to do outpatient counseling services?**
  - *For now, the requirement is to have certified level peers/staff. However, SAPC is currently developing a staffing grid which will aid in determining what level of services registered counselors can perform, and what approach to take in phasing in staff level requirements.*
- **What should be the frequency of post-discharge transition follow-up?**
  - *Flexibility is important with RSS. Frequency will depend on the patient needs and medical necessity and any limits on RSS services.*

- **How often should re-assessment be conducted for medical necessity?**
    - *Usually, every six months. Per Medi-Cal, there is a requirement for a continuing justification for medical services every six months.*
- **Should providers then conduct a new assessment with RSS patients every six months to establish medical necessity?**
    - *SAPC will follow up with DHCS to obtain clarification.*
- **If the patient is already recovering from SUD, he or she will eventually fail to meet medical necessity for SUD services. How could providers then still conduct RSS to such a patient given the medical necessity re-assessment requirement?**
    - *There must be a balance between ongoing relapse prevention and meeting recovery goals. SAPC will ask the State about medical necessity requirements for patients who are in continuous recovery and receiving RSS beyond six months.*
- **Should providers then conduct a new assessment with RSS patients every six months to establish medical necessity? Do patients still need to meet three or more dependence criteria for SUD to qualify for RSS?**
    - *This will be required unless otherwise determined based on discussion within SAPC and with DHCS.*
- **Since there is currently no assessment tool for ongoing RSS, do patients still need to meet medical necessity?**
    - *Yes, see additional information in questions above.*
- **Is tobacco cessation therapy allowable under outpatient counseling services?**
    - *It qualifies under health and wellness goals, provided that the patient meets medical necessity for DMC services, and that the issue of tobacco use is in conjunction with SUD.*
- **If medical necessity had been initially met for SUD treatment, could that suffice for allowing RSS post-discharge?**
    - *There is, unfortunately, a State requirement for meeting medical necessity for RSS. At its broadest definition, medical necessity is about avoiding harm to patients. There is a way for providers to frame justification for RSS due to high relapse risk based on the DSM-V. Per the State, initial medical necessity needs to be determined at the beginning of treatment, which is then re-confirmed within six months. SAPC needs to inquire with the State what happens at the six-month mark.*
- **From a provider standpoint, how can we reconcile treating SUD as a chronic condition and at the same time meet the medical necessity requirement? How can we use DSM-5 specifiers to help?**
    - *Regarding medical necessity requirements, SAPC will ask the State for clarification. The fact is, with the newly reimbursable RSS, the bar will be set high. There will be plenty of room to document patient services and status to justify continued need for RSS. Services and patient interactions need to be documented upfront to qualify for reimbursement, and providers need to articulate patients' need for RSS in the plan.*

- **Since recovery services need to be indicated in the treatment plan, what happens when a patient moves from one provider or level of care to another? Should providers open a new case for RSS post-discharge?**
    - *The treatment plan should follow the patient all throughout the continuum of care. Post-discharge, the plan may no longer be in its original form but the focus should be on the content and history of treatment. Under RSS, the plan's format may be modified depending on patient status.*
- **Medical necessity is separately required for initial SUD treatment and RSS, correct?**
    - *Yes.*
- **We have been discussing providing RSS for adults. How about the youth and tailoring RSS according to their needs?**
    - *RSS lends itself to flexibility depending on patient need.*
- **Can recovery monitoring be considered a field-based service?**
    - *There will be a specific stakeholder workgroup meeting on field-based services.*
- **Will we include telehealth as mandatory for recovery monitoring? Can recovery coaches conduct services through telehealth?**
    - *It will depend upon state regulations. SAPC will verify. Documentation will become much more important, if approved. There may also be limits on who can provide and bill telehealth. Need clarity from the state.*
- **Do recovery coaches need to be certified? Are they the same as certified rehabilitation counselors (CRC)?**
    - *They are two different titles depending on the state. SAPC is currently looking at instituting a training program to qualify recovery coaches as staff who can bill for services.*
- **Is there a reason for the 21-year-old limit for peer specialists? Providers may face legal repercussions for disqualifying people under the age of 21 who can work.**
    - *The idea behind the requirement is to avoid the peer specialists being older or younger than the patients they will be serving. Peer specialist should be able to identify with the patients they are working with, typically within the same age range. SAPC will inquire about imposing such a limit.*
- **Providers do not have peer specialists and CRCs among their staff. Can providers have higher level staff perform recovery monitoring or RSS in general?**
    - *It is generally not a problem for staff to work at a level lower than their title. Providers just need to determine how viable that practice is for their business. However, in order to be a peer specialist, the person needs to have "lived experience", and higher level staff may not meet that requirement.*
- **Should Licensed Practitioners of the Healing Arts (LPHA) be trained for recovery coaching?**
    - *For now, they do not need to be trained but they need to be certified.*

	- **Will individuals transitioning from the jail and similar institutions have access to substance abuse assistance, and will providers be able to bill for such service accordingly?**
	  - *Per the State, RSS will be reimbursable only after the patient has gone through SUD treatment. If the patient did not undergo SUD treatment that aligns with the DMC-ODS requirements while in custody, he or she cannot benefit from RSS. Another case is when a patient who had undergone SUD treatment becomes incarcerated. He or she may take advantage of RSS upon discharge depending on the State's determination of the time-lapse between when treatment was provided while incarcerated and the need for RSS.*
	- **RSS is available for which level of care? How about outpatient?**
	  - *RSS is available after discharge from all levels of care, including outpatient.*
	- **What proof is needed for a patient to transition to or continue receiving RSS?**
	  - *Treatment plan may serve as proof. Self-attestation is not admissible.*
	- **Does a patient need to be an "at-risk youth with history of non-engagement" to qualify for Substance Abuse Assistance service? Is this service just for them?**
	  - *No, the list of recommended populations under that service component does not pertain to eligibility criteria. Rather, it pertains to patient cases that Substance Abuse Assistance may particularly focus on.*
	- **Can we use RSS to engage individuals who have not gone through treatment? For how long until we consider a non-engaged patient to be lost to follow-up? How long can a client be kept open in outreach before needing to be discharged?**
	  - *Per the State, an individual needs to have gone through treatment to qualify from RSS. The opportunity that we have with this demonstration period is to see what we can improve on beyond the Waiver. For the pilot, however, we need to be precise with the parameters, and then get broader later.*
	- **For out-of-state patients, or patients coming from other county DMC programs, do they need to be re-assessed for SUD at a DMC-certified facility?**
	  - *SAPC will verify with the State.*
	- **Should RSS be capitated or fee-for-service (FFS)?**
	  - *There will likely be limits to the number of RSS services per year. SAPC will share this information if/when determined. If there is a move from FFS to capitation, the State is open to a new billing structures.*
	- **For Education and Vocational Support Services, should providers hire job coaches?**
	  - *Per the State, the staff would provide linkages not job services per se. The service is all about managing the process, and directing patients to resources, among others. The peer support specialist continues to connect with the patient for progress on activities and services the patient is engaged in.*

	- **If Education and Vocational Support Services are merely about linking patients to resources and services, do providers still need to hire certified staff to do the job?**
	  - *SAPC may need to adjust the staffing requirements.*
	- **Can providers link for services within their system or agency, and bill accordingly?**
	  - *Self-referral is an issue. Medi-Cal needs documentation to ensure consumer protection. SAPC needs to ask the State about regulations surrounding this concern. There are, however, ways to view this linking of services within an agency using the holistic treatment lens, which needs to be articulated in the treatment plan.*
	- **What do other states have as total RSS hours per year?**
	  - *HMA will provide the data of the average hours per year across states.*
	- **Is there any flexibility regarding group size?**
	  - *The State is firm about limiting it to 12 patients. Larger groups make it difficult for the counselor to manage patients' progress relative to set goals and treatment plans.*
	- **Are providers required to conduct all of RSS components to patients?**
	  - *RSS is voluntary and not mandatory for patients and it follows patient preferences, and allows for flexibility. RSS should be tailored around the patient's needs.*
	- **Family support is currently part of collateral services. With RSS, it has become its own category, alongside other RSS components. Many times, it is convenient and realistic to conduct multiple services with a patient during the day he or she comes to our facility. How can we bill for services conducted in a day?**
	  - *Same-day billing is allowed under the Waiver, but with caution. State guidance is needed for billing across different funding agencies as well as multiple services provided on the same day. Overall, providers need to be careful with documentation.*
	- **Do providers need to contractually apply for RSS?**
	  - *All SAPC treatment providers are automatically qualified to conduct RSS since it is available for all levels of care. RSS will just need to be added in the contract statements of work.*
	- **Are there initial attempts to establish a SAPC-approved Certified Peer Specialist training?**
	  - *SAPC is in the process of exploring this possibility. There are national standards and processes SAPC can reference. Some states have hired universities or training institutes to train, administer tests to, and certify peer specialists.*

V. Next Steps	SAPC, with HMA, will revise the RSS document. Providers will be notified of follow-up meetings and will be furnished with the full RSS narrative for the stakeholders' review and feedback. Additional feedback may be sent through SAPC's website or email at SUDTransformation@ph.lacounty.gov. Meeting notes will be posted online.